LAB

NUNM Health Centers Patient Registration – Lab Services

Patient's Legal Name:

____

Last Name First Name Middle Name

The information you provide helps us to serve you and other members of the community and assists us to help you reach your health goals. Please write legibly and answer all questions.

Please check this box if you do NOT want to receive news and updates from NUNM

What is your preferred first name? (Nickname, chosen name, etc.)______________________________

Social Security Number:____________________________________Birth Date_____________________

Sex: Female ________ Male__________ F2M Trans_______ M2F Trans________

Address:____

City: _____________________________________ State: ____________ Zip code: _________________

Contact information (*please circle preferred number for contacting you*):

Home telephone: ___________________________ Work phone: ________________________________

Cell phone: ________________________________ Email address: ______________________________

Interpreter needed? Y N Language: __________________________________

Homeless? Yes No At Risk for Homelessness? Yes No

Seasonal or Migrant Worker? Seasonal Migrant Neither US Veteran? Yes No

Ethnic Group (Select One): □ Hispanic □ Non-Hispanic

Race (You can select more than one): □ Asian □ Black □ White

□ Native Alaskan □ Pacific Islander □ American Indian

Occupation:____Hours per Week: _____

Employer:_______________________________Address:____

City:___________________________________State:____________________Zip:____________________

Phone:________________

Employment Status (Check one): □ Full Time □ Part Time □ Retired □ Seasonal

□ Self-Employed □ Student (Full Time) □ Student (Part Time)

Emergency contact: ____

Relationship: ____________________Telephone number: _______________

Guarantor: The person who is financially responsible

Name:___________________________Relationship to the patient:__________

Address: (if different from patient) ______________________________

City:_____________________________State:__________Zip:_________

Social Security Number: _______________ Gender: M F Birth Date:_________

Guarantor Language:________________

The NUNM Health Centers Billing Dept requires that ***all*** insurance coverage be pre-verified (7 business days) before we are able to bill for you. If this process has not been completed ahead of your appointment time, we will provide documentation of your visit to submit to your insurance company. You will be given any applicable discount for your office visit.

Insurance Company: ____

Claims Address: ____

City: _______________State: ______ Zip: ________ Phone#: ___________

Group/Policy # _______________________Subscriber ID#________________

Patient ID #________________

Please be prepared to present your insurance card at check-in at each visit.

I certify the above information is true and correct to the best of my knowledge.

Signature:__________________________________**Date:**__________